

PRIOR AUTHORIZATION CRITERIA

BRAND NAME*
(generic)

OSPHERA
(ospemifene)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Osphena is indicated for:

- The treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy, due to menopause.
- The treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy, due to menopause.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of any of the following: A) Moderate to severe dyspareunia (pain during sexual intercourse) due to menopause, B) Moderate to severe vaginal dryness due to menopause

REFERENCES

1. Osphena [package insert]. Florham Park, NJ: Shionogi Inc.; January 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2021; Accessed December 2, 2021.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com>. Accessed December 2, 2021.